Washington State Health Care Authority

HCA Monthly Tribal Meeting

September 25, 2017

Jessie Dean
Administrator, Tribal Affairs and Analysis
Office of Tribal Affairs

Washington State Health Care Authority

Welcome, Blessing, Introductions

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Agenda

9:00 AM	Welcome, Blessing, Introductions
9:10 AM	Discussion with HCA Interim Director Lou McDermott
9:25 AM	Schedule Changes for the Monthly Tribal Meeting
9:30 AM	New HCA Opioid Prescribing Policy
10:00 AM	Oral Health Connections Pilot Project + Managed Care Dental RFP
10:30 AM	Integrated Managed Care – Update on Implementation
10:50 AM	Medicaid Transformation Demonstration – Initiative 3
11:10 AM	Medicaid Transformation Demonstration – Initiative 1 • Indian Health Care Provider Planning Funds
11:50 AM	Updates on State Plan Amendments • DHAT • IHS Encounter Rate • Tribal FQHC
Noon	Closing

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Discussion with Interim Director Lou McDermott

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Proposed Schedule Changes for MTM

- No MTM in October
- Next MTM on November 7, 9:00 a.m. – Noon
- Starting in December, MTM on 1st Wed of the Month
  - December 6
  - January 3
  - February 7
  - March 7
  - April 4
  - May 2

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HCA Opioid Prescribing Policy

Clinical Quality and Care Transformation
September 25, 2017

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Agenda

- Background
- HCA Opioid Prescribing Policy
- Additional Resources

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In 2013

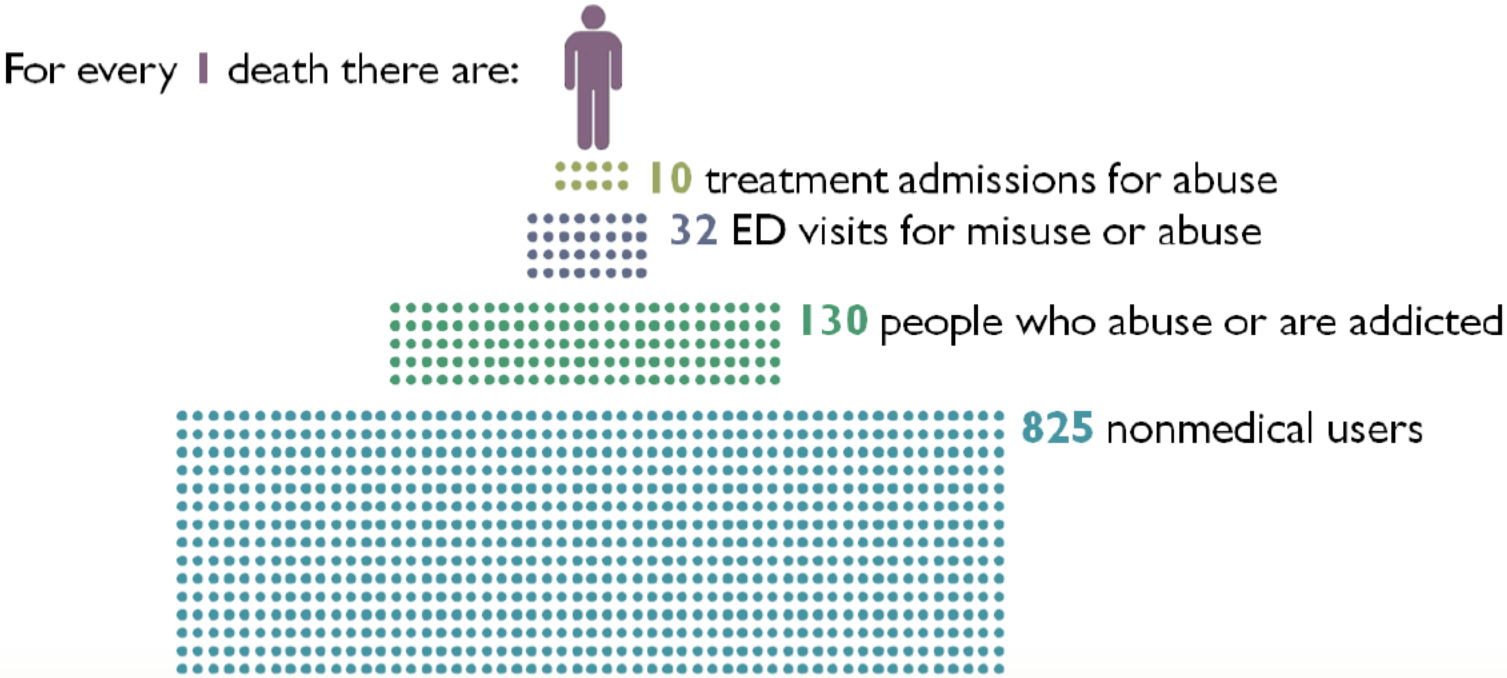
43,982 Americans

DIED FROM DRUG POISONINGS

Nearly 16,235 deaths involved prescription opioids

In 2008

For every 1 death there are:



NCHS Data Fact Sheet, June 2015 http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf
CDC. Policy Impact: Prescription Painkiller Overdoses. http://www.cdc.gov/homeandrecreationalsafety/rxbrief/ (Historical content - 2008 data) (accessed on 1/6/15).

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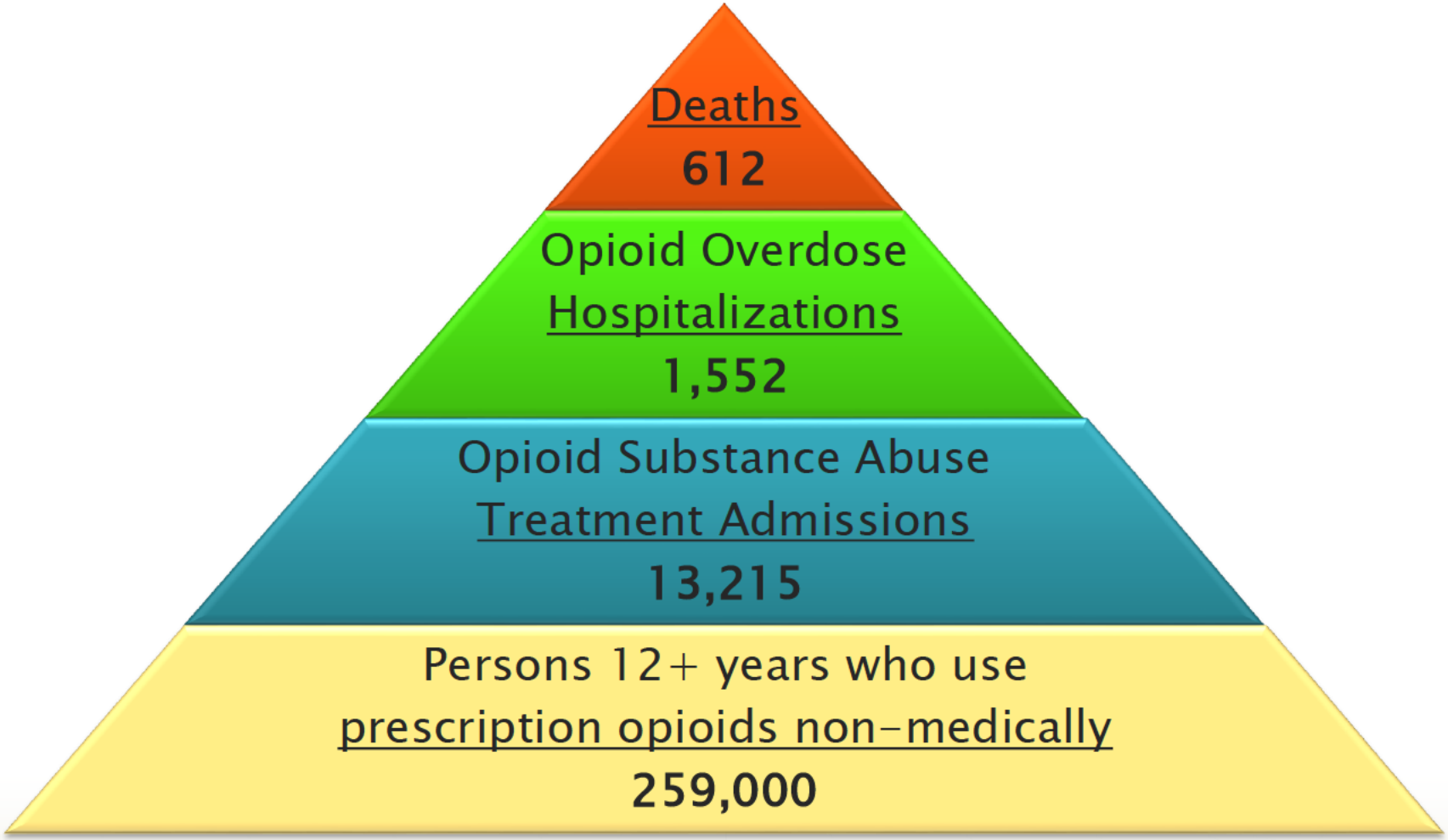
Opioid-related Disease Burden in WA



1.Opioids involved in an unintentional overdose death listed as underlying cause of death. Washington State death certificate data, 2014.
2.Washington Hospital Discharge Data, Comprehensive Hospitalization Abstract Reporting System (CHARS) and Oregon State Hospital Discharge Data , 2014.
3.Treatment and Assessment Report Generation Tool, 2014
4.National Survey on Drug Use and Health, 2013-2014

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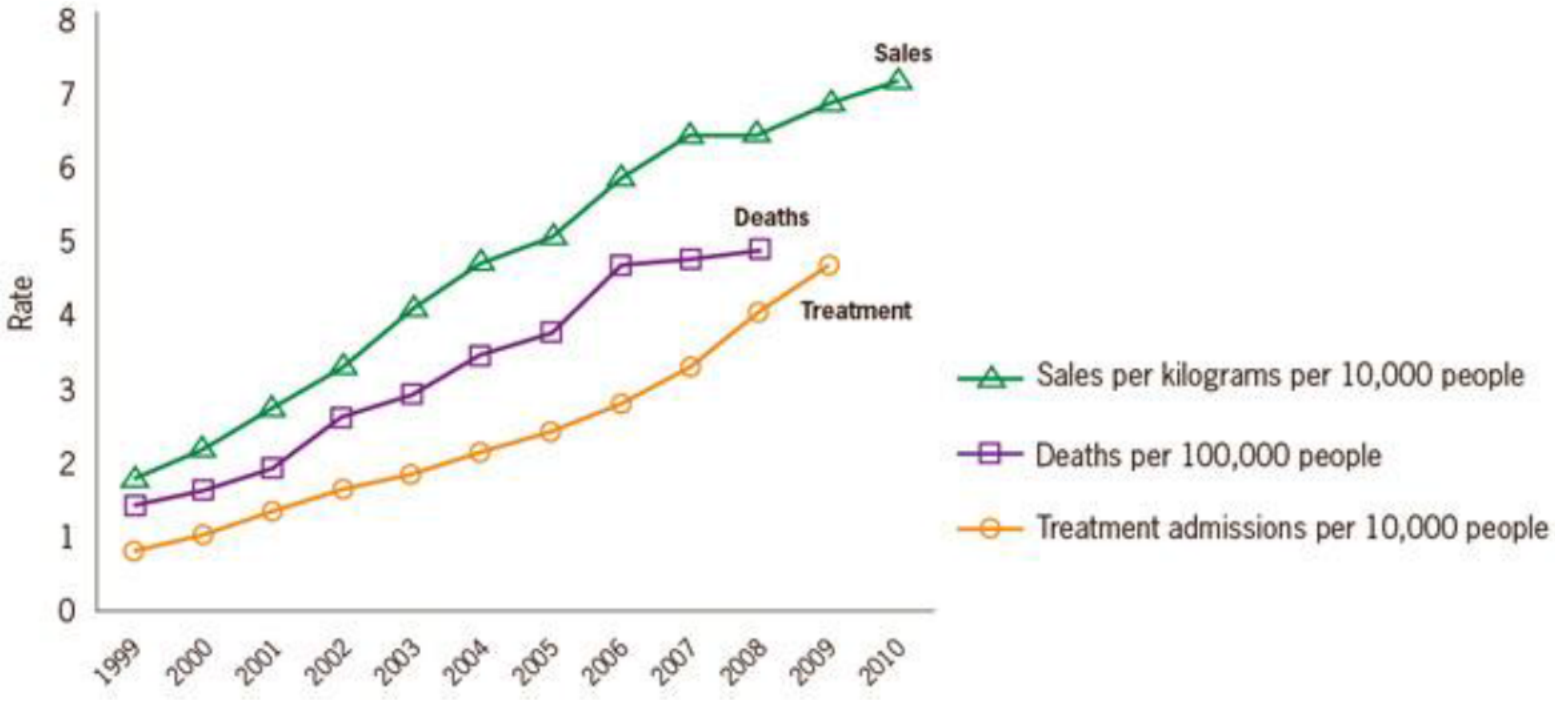
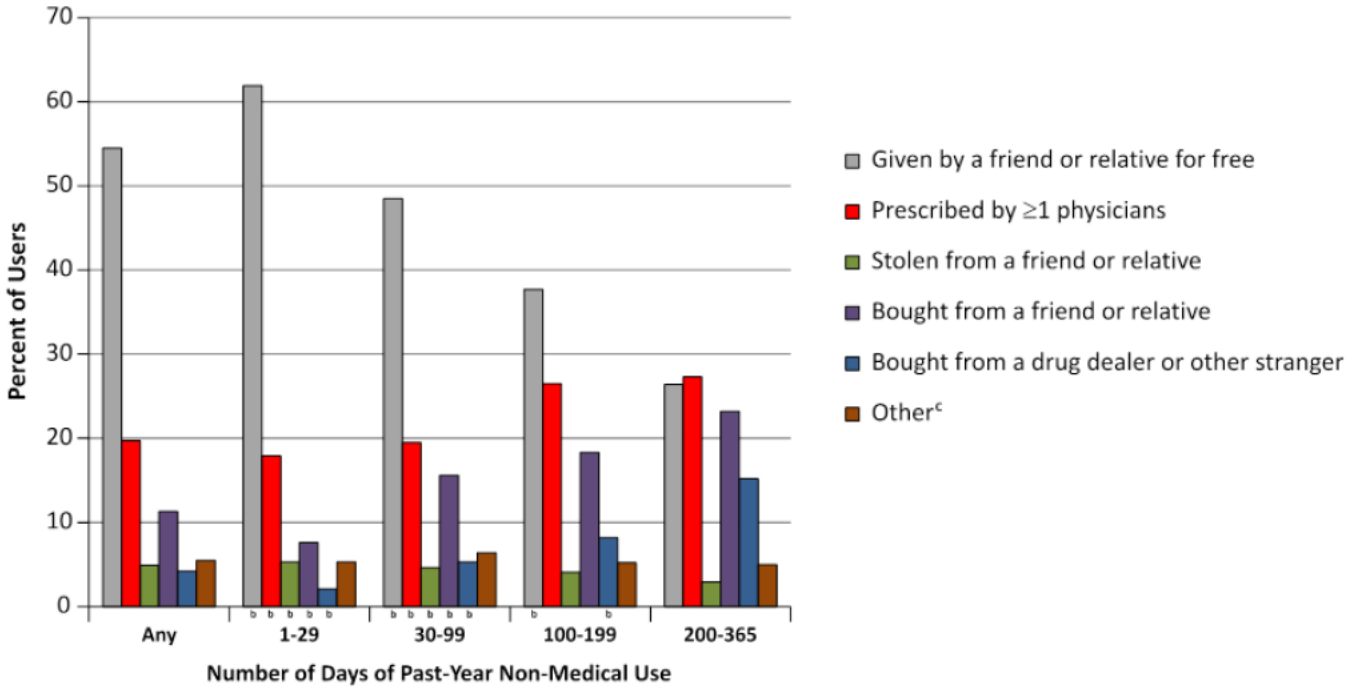
Prescription Painkiller Sales, Deaths and Substance Abuse Treatment Admissions: 1999-2010



Sources: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders Systems of the DEA, 1999-2010; Treatment Episode Data Set, 1999-2009.

Sources of Prescription Painkillers Among Past-Year Non-Medical Users[a]



[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[5]
[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).
[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

SOURCE: Jones C, Paulozzi L, Mack K. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008–2011. JAMA Int Med 2014; 174(5):802-803.

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Opioid prescription use relationship to heroin use

The JAMA Network

From: **The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years**

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

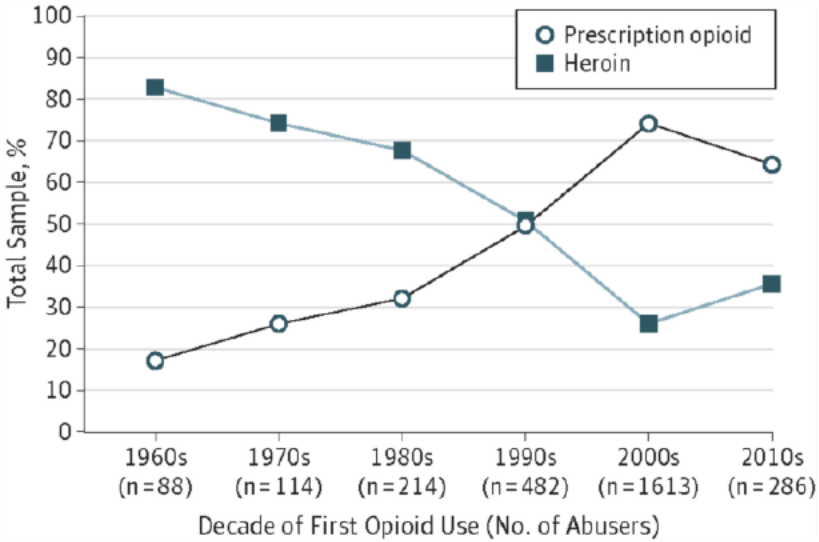

Figure Legend:

Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of AbuseData are plotted as a function of the decade in which respondents initiated their opioid abuse.

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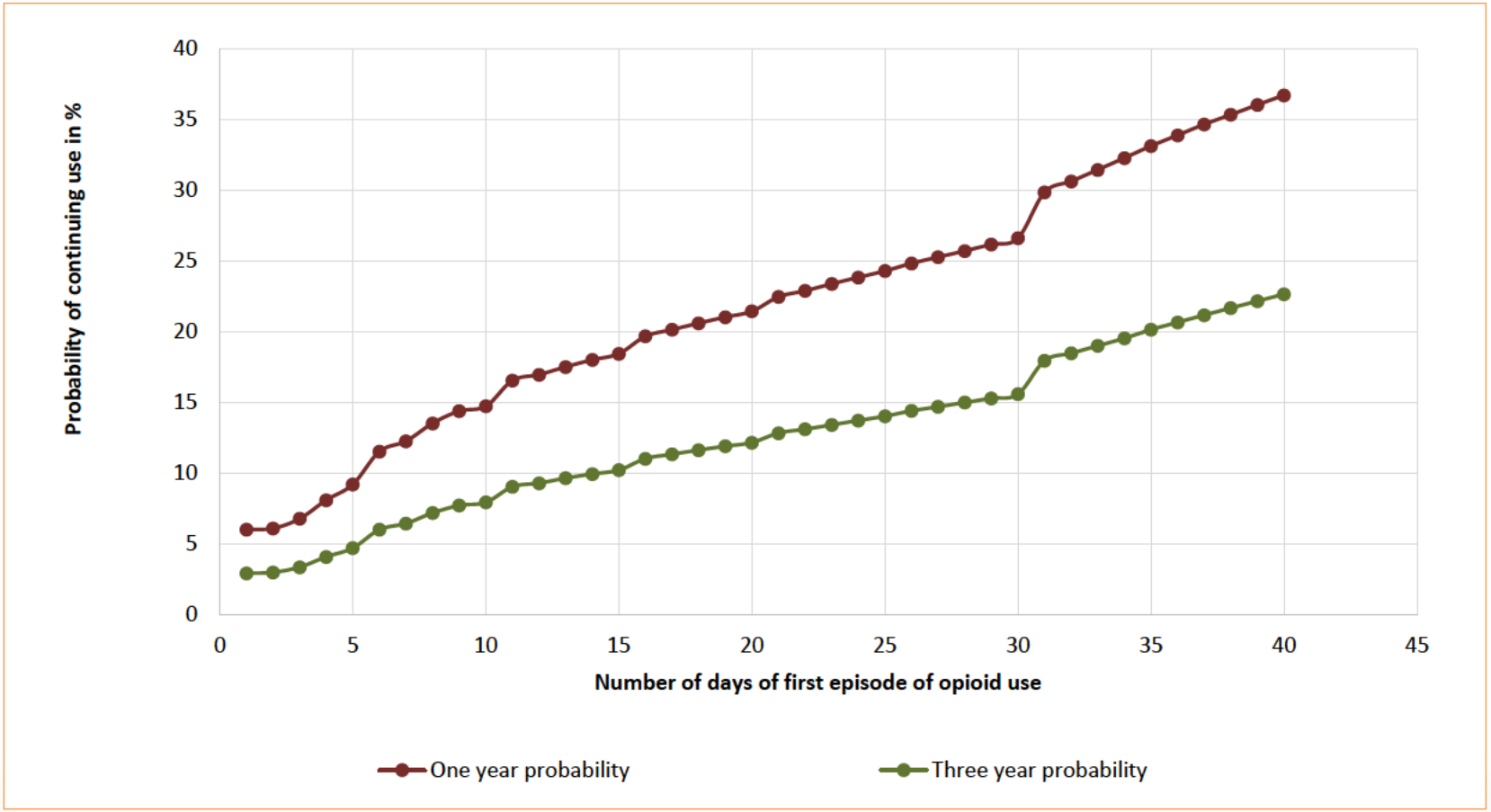
Acute Opioid Prescriptions: Continued Use by Initial Days of Therapy



From: MMWR. 2017 Mar 17; 66(10):265-269

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Opioid Pills Needed Post-Op*

- Surgery
  - Partial mastectomy (N=58)
  - Sentinel node bx (N=62)
  - Laparoscopic cholecystectomy (N=58)
  - Hernia repair (N=27)
  - Open inguinal hernia (N=18)
- Mean (SD) pills taken
  - 1.8 (3)
  - 1.9 (3)
  - 7.5 (8.3)
  - 9.7 (10.7)
  - 2.8 (7.7)

*From: Hill et al. Ann Surg 2017. Mar 6 doi:10.1097/SLA.0000000000002198

Governor's Executive Order

- In October 2016, Governor Inslee issued Executive Order 16-09.
  - Directed the state's agencies and resources to combat this crisis.
  - Efforts include preventing opioid use disorder as well as treating it
  - http://www.governor.wa.gov/sites/default/files/16-09OpioidPreventionE.pdf

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Medicaid Opioid Prescribing Policy

- Effective November 1, 2017
  - ***Note change in implementation date***
- Consistent policy across all 5 Medicaid managed care plans and fee-for-service

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Our Goals

- Reduce unnecessary exposure
- Reduce unused pills in community
- Ensure safe transitions and best practices when chronic use is needed
- Minimize administrative burden on providers
- Encourage adherence to guidelines while recognizing clinical need for exceptions

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Acute Use

- Only short-acting opioids will be approved for acute use unless an exemption is requested.
- Limits apply as follows (unless an exemption is requested):
  - Children (under 21) are limited to 18 doses (pill or liquid) (about a 3 day supply)
  - Adults (21 and over) are limited to 42 doses (pill or liquid) (about a 7 day supply)

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Transition to Chronic Use

- At 6 weeks (beyond 42 days of treatment in a 90 day period), you will need to sign and send in a form attesting that you are following best practices as outlined by CDC guideline for chronic opioid prescribing (https://www.cdc.gov/drugoverdose/prescribing/guideline.html)
- You do not need to send in documentation of these practices, but documentation should be in the chart if an audit is performed
- If some of the practices do not apply, simply document the reason in the chart
- You must sign the form; your staff cannot do this for you
- For the full detail on the attestation form, please read the opioid policy on the HCA website: https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf

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Examples from Attestation Form

- The patient has an on-going clinical need for chronic opioid use
- The patient is using or has tried and failed appropriate non-opioid medications, and/or non-pharmacologic therapies
- The patient has been screened for mental health disorders, substance use disorder, naloxone use
- The provider will conduct periodic urine drug screens
- The provider has checked the PDMP for any other opioid use and concurrent use of benzodiazepines and other sedatives
- The provider has discussed with the patient the realistic goals of pain management therapy
- The provider confirms that the patient understands the risks and benefits of chronic opioid use

- For the full detail on the attestation form, please read the opioid policy on the HCA website: https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf

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Exemptions

- "Exempt" process: Provider types "exempt" on the script to override acute pill limits
- Grandfathering (more details below)
- Patients in hospice, end of life or palliative care, or being treated for active cancer pain (write this on the prescription)
- Patients who are new to a health plan within 120 days

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Grandfathered users

- Patients are to be grandfathered if there is a history of use of an opioid for ≥ 90 calendar days in the previous 120 days
  - Patients who meet this criterion are "grandfathered" under the policy, and can continue to receive opioid prescriptions without prior authorization
  - Includes patients who are new to a plan who get 90 days' fill in the first 120 days
- All other limits described elsewhere do not apply to grandfathered patients

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Opioids affected by New Policy

- Codeine
- Fentanyl
- Hydrocodone
- Hydromorphone
- Meperidine
- Morphine
- Oxycodone
- Oxymorphone
- Tapentadol
- Tramadol

<u>Opioids not affected by this policy:</u>

- Buprenorphine
- Methadone

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Issues not addressed by November 1st Implementation

- MED limits:
  - We are delaying the incorporation of dose limits in the policy in order to develop a process that addresses the needs of clinically complex and diverse populations
- Management of patients with opioid use disorder:
  - Efforts are underway statewide to support treatment availability, but this is outside the scope of this policy

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Opioid Prescribing Resources

- WA State Prescription Monitoring Program (PMP)
  - http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/PrescriptionMonitoringProgramPMP
- WA State Agency Medical Directors Guideline
  - http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf
- CDC guideline
  - https://www.cdc.gov/drugoverdose/prescribing/guideline.html
- HCA additional information:
  - https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

Opioid Prescribing Resources

- UW TelePain
  - A service for community-practice providers to increase knowledge and skills in chronic pain management
    - http://depts.washington.edu/anesth/care/pain/telepain
    - Questions: telepain@uw.edu
- UW Pain Hotline
  - "Real time" consultations for clinicians caring for patients with complex pain management regimens, particularly high dose opioids
  - 1-844-520-PAIN (7246) (Mon-Fri from 8:30 am – 4:30 pm)

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Additional Questions

More Information:

https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

Oral Health Connections Pilot Project

2017 Legislative Budget Proviso 5048

- Directed Health Care Authority (HCA) to partner with the Washington Dental Services Foundation to implement this pilot
  - Arcora, formerly known as the Foundation has partnered with HCA to develop and implement this pilot
- Pilot will be pattered after the ABCD Program
- Purpose of the Pilot is to test the effects of enhanced oral health services on the overall health of two populations:
  - Pregnant Women
  - Clients with Diabetes
- The pilot clients will be afforded all of the existing dental benefits plus up to three additional periodontal maintenance visits per calendar year

2017 Legislative Budget Proviso 5048

- Pilot dentist will receive enhanced rates for the pilot CDT codes and regular Medicaid rates for all other billed CDT codes

- Components of this comprehensive pilot program include:
  - Dental and Medical provider training;
  - Coaching;
  - Support and Collaboration in diagnosis and treatment of diseases;
  - Patient Outreach and education; and
  - Coordination by local entities

Pilot Locations and Enhanced Payments

- The pilot will take place in the following counties:
  - Spokane
  - Thurston
  - Cowlitz
- Enhanced Payment will be for the following services:
  - Office Visit - Comprehensive Oral Evaluation (**CDT D0150**)
  - Diagnostic Services - Radiographs (**CDT D0210 & D0274**)
  - Periodontics Services - (**CDT D4341, D4342 & D4910**)

Oral Health Connections Pilot Implementation

- Presently looking at an implementation date of January 1, 2019
- HCA and Arcora Foundation are jointly working on the development of the pilot
- Still determining the best delivery system for implementing the pilot project
  - Through the HCA fee for service model; or
  - Through the upcoming contracting dental managed care organization to jointly implement this pilot in the three designated counties with the HCA

Oral Health Connections Pilot Project

- Questions

- Contact:
  - Casey Zimmer
    - Casey.Zimmer@HCA.WA.GOV
    - 360-725-1822

Managed Care Dental Request for Proposal (RFP)

2017 Legislative Session - SSB 5883

Proviso Overview:

- Directed Health Care Authority to contract through a competitive procurement process with licensed health plans or managed health plans to provided managed dental care services.
- Must contract with 2 plans, where only one is available, FFS will remain.
- Must ensure that savings offered by dental plans are actuarially sound.
- No start up costs will be provided to plan(s).
- Additional savings achieved beyond the assumed amount with be used to increase dental provider reimbursement rates.
- The pilot clients will be afforded all of the existing dental benefits plus up to three additional periodontal maintenance visits per calendar year.

2017 Legislative Session - SSB 5883

- Contract must include:
  - Quarterly reporting requirements to include Medicaid utilization and encounter data by CDT code;
  - Direction to increase dental provider network;
  - Commitment to retain innovative programs that improve access and care;
  - A program to reduce emergency room use for dental purposes;
  - A requirement to ensure that dental care is being coordinated with the PCP for the purposes of integrated care;
  - A provision that no less than 85% of the contracting fee be used to offset costs; and
  - A provision to ensure contracting fee shall be sufficient to compensate county health departments and FQHCs for dental patient care

2017 Legislative Session - SSB 5883

- Managed Care Dental will be implemented January 1, 2019
  - Statewide procurement
  - Dental plan(s) may vary by region based on network adequacy
  - American Indian and Alaska Native populations will be able to choose between managed care and fee-for-service (which will remain)
- Current Status:
  - In the process of information gathering

Managed Care Dental - RFP

- Questions

- Contact:
  - Jennifer Coiteux
    - Jennifer.Coiteux@HCA.WA.GOV
    - 360-725-2129

Update on Implementation Efforts:
Integrated Managed Care

Jessica Diaz
Health Care Authority
September 25, 2017

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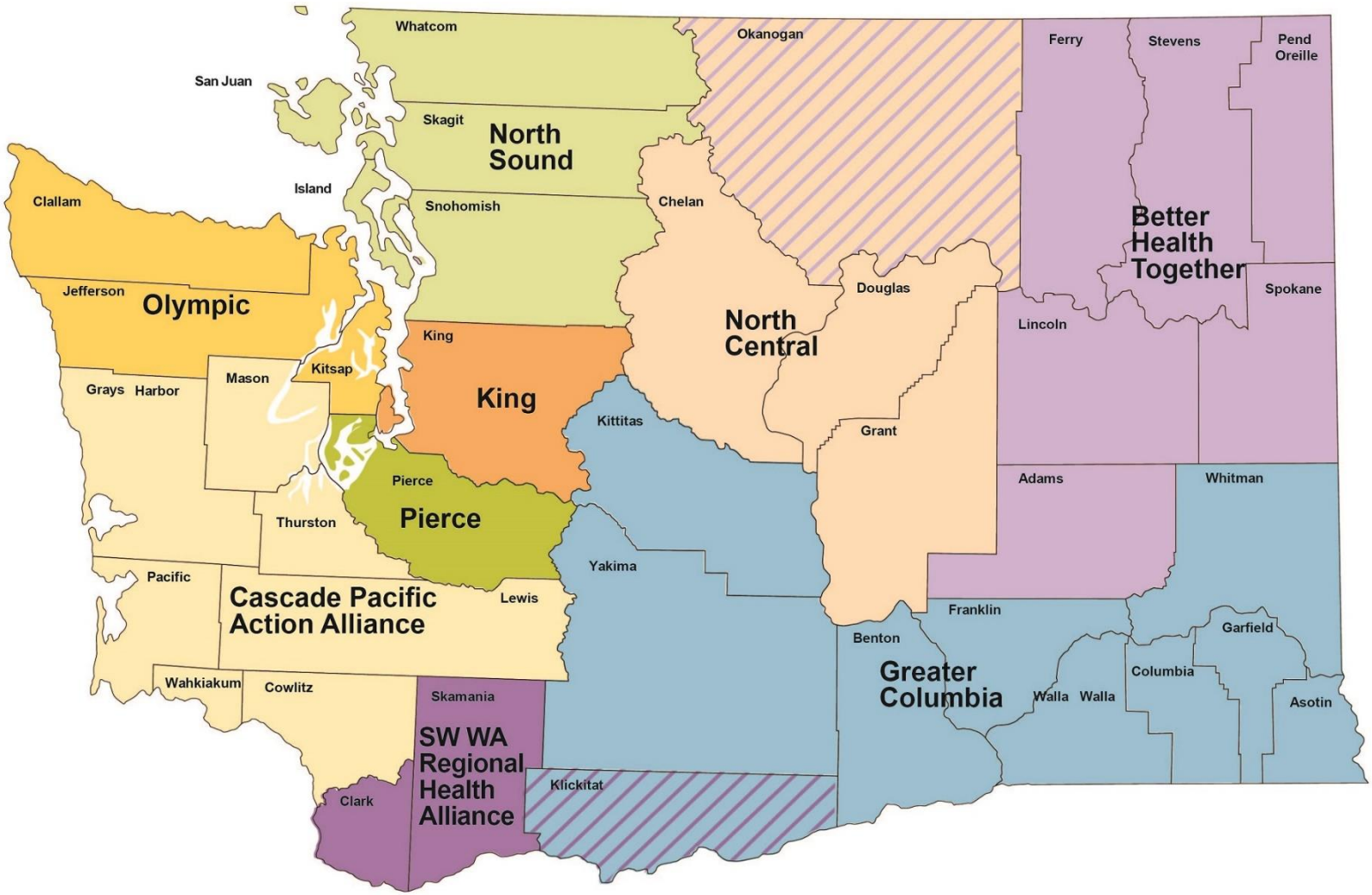
Update on Adoption Status



Maintaining the Spirit of ESHB 1388

2016.28 NEW SECTION. Sec. 4065.

A new section is added to chapter 71.2429RCW to read as follows:

(1) The authority shall, upon the request of a county authority or authorities within a regional service area, collaborate with counties to **create an interlocal leadership structure** that includes participation from counties and the managed health care systems serving that regional service area. The interlocal leadership structure must include representation from physical and behavioral health care providers, tribes, and other entities serving the regional service area as necessary.

(4) To ensure an optimal transition, regional service areas that enter as mid-adopters must **be allowed a transition period of up to one year** during which the interlocal leadership structure develops and implements a local plan, including measurable milestones, to transition to fully integrated managed care. The transition plan may include provisions for the counties' organization to maintain existing contracts during some or all of the transition period if the managed care design begins during 2017 to 2018, with the mid-adopter transition year occurring in 2019.

Next Steps

- **January 1, 2018**: Implementation in Chelan, Douglas, and Grant counties
- **Nov 2017-Feb 2018**: Development and Release of Statewide RFP for MCO Selection
- **Dec 2017-Mar 2018**: Development and Release of Statewide RFP for BH-ASO Selection
- **January 1, 2019**: Implementation of 2019 Mid-Adopters
  - Full implementation – No transition; or
  - Transitional implementation
- **January 1, 2020**: Implementation of remaining regions

Soliciting Feedback and Input

HCA Contacts

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Foundational Community Supports (FCS)

Supported employment services

Individual Placement and Support (IPS) model

Principles of supported employment

- Open to anyone who wants to work
- Focus on competitive employment
- Systematic job development
- Prioritize rapid job search
- Client preferences guide decisions
- Individualized long-term supports
- Integrated with treatment

Services may include

- Employment assessment and development of a plan to address barriers
- Assistance with applications, community resources and outreach to employers
- Education, training, coaching to maintain employment

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Supported employment eligibility criteria

- Health Needs (medical necessity)
- Risk Factors:
  - Those eligible for HEN/ABD (unable to work for 90+ days due to incapacity)
  - Behavioral health conditions, including
    - Serious mental illness
    - Multiple inpatient SUD treatments
    - Youth in transition (16+)
  - LTSS recipients unable to be employed due to conditions related to age, physical disability or TBI.

Supportive housing services

Community Support Services	Housing assessment and development of a plan to address barriers
	Assistance with applications, community resources, and outreach to landlords
	Education, training, coaching, resolving disputes, and advocacy

*Supportive housing services **do not** include funds for room and board or the development of housing.*

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Supportive housing eligibility criteria

- Health needs (medical necessity)
- Risk factors
  - Chronically homeless (HUD definition)
  - Frequent/lengthy institutional contact
  - Frequent adult residential care stays
  - Frequent turnover of in-home caregivers
  - PRISM Score 1.5+

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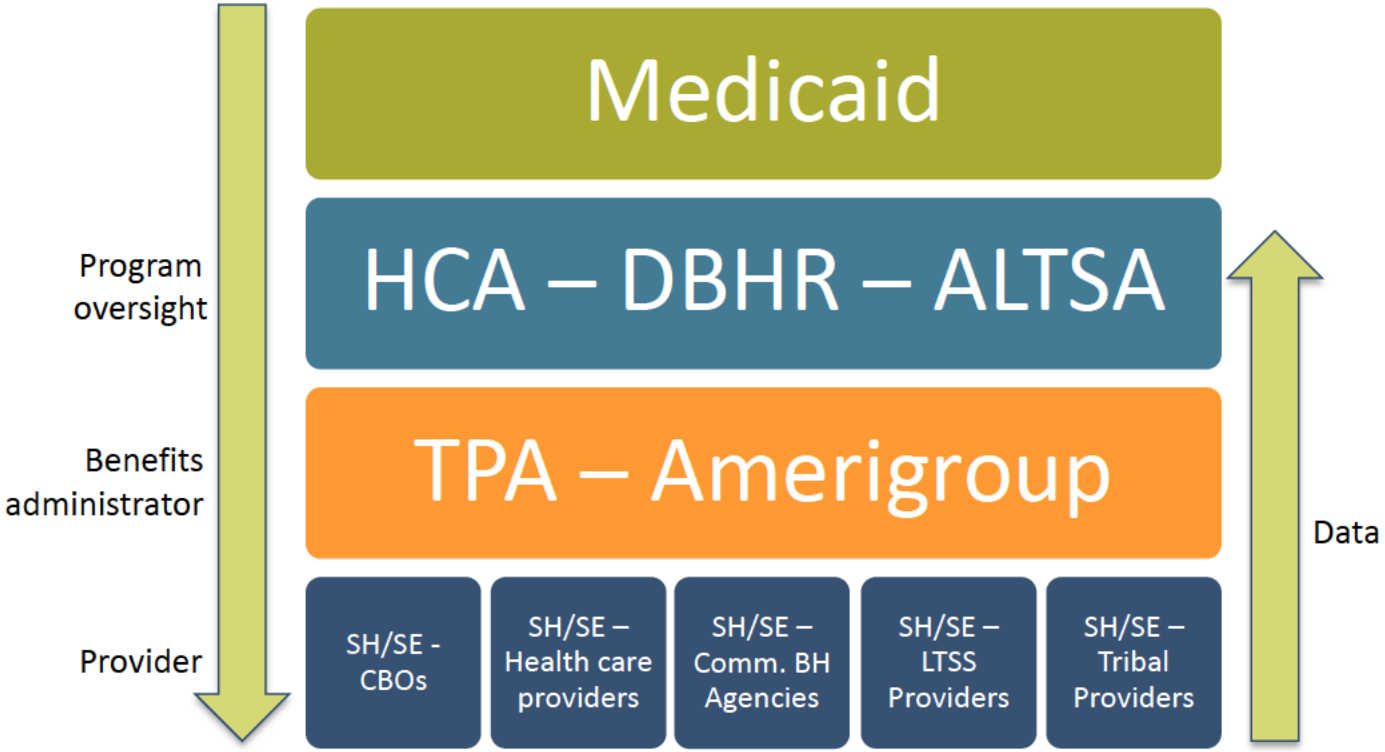
Third Party Administrator - Amerigroup

Medicaid funds flow
Current Model



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What is a third party administrator?

- Contracted with the state
- Provides administrative oversight of benefit programs
  - Provider network development and maintenance
  - Service authorization
  - Distribution of reimbursement payments
  - Data/encounter tracking

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For FCS Providers

- Single contracting entity for both benefits
- HCA, BHA and ALTSA will provide technical assistance and consultation
- Licensed/certified CBHAs, LTSS providers will have the opportunity to provide FCS services

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For FCS Beneficiaries

- Single point of accountability
  - Benefit eligibility decisions
  - Service authorization
  - Grievances & Appeals

FCS Tribal engagement

- Amerigroup will engage tribal governments and IHCPs to support coordinated and culturally appropriate services
- Tribal providers can contract with Amerigroup directly to participate in FCS services, per FCS and Tribal protocols

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Foundational Community Supports
Next steps

Foundational Community Supports protocol

- Protocol must be approved before services can be provided
- Currently with CMS General Counsel

Third party administrator

- Amerigroup – Torri Canda, FCS Director, torri.canda@Amerigroup.com

WAC

- HCA: Program authorization – Emergency WAC Revisions in process
- DBHR: Certification WAC – Emergency WAC finalized

Initial provision of services to begin after protocol approval

- Benefits will be provided statewide

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Contact Information

- Jon Brumbach, HCA
  - Jon.Brumbach@hca.wa.gov
  - 360.725.1535
- Torri Canda, Amerigroup
  - Torri.canda@Amerigroup.com

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Indian Health Care Provider Planning Funds

Medicaid Transformation Demonstration – Initiative 1

Washington State Health Care Authority

IHCP Planning Funds

Next Steps Since Last Meeting:

- HCA to provide guidance/suggestions on what milestones should be used.
- HCA and tribes/UIHPs to develop:
  - Work plan for completion of milestones, and
  - Timeline for moving the work forward, including dates for meetings and target deadlines.
- Tribes/UIHPs to provide:
  - Tribal and UIHP profiles,
  - Epidemiological reports from NPAIHB and UIHI, and
  - Tribal and UIHP investments to date into the Medicaid Transformation Demonstration and precursors.

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IHCP Planning Funds: Guidance on Milestones

[Go to Draft IHCP/Tribal Protocol]

Medicaid State Plan Amendments - Updates

Medicaid State Plan Amendments

SPA 17-0027: Dental Health Aide Therapists

- Submitted on August 22, 2017
- Currently under CMS review

[Go to Draft SPA 17-0027]

Medicaid State Plan Amendments

SPA 17-0042: Update of All-Inclusive Rate

- To be submitted by September 29, 2017
- Used 10 day expedited tribal/IHCP review period to be able to back-date SPA to July 1, 2017

[Go to Draft SPA 17-0042]

Medicaid State Plan Amendments

SPA 17-0028: Tribal FQHC

- Seeking guidance from CMS on various technical questions
  1. Scope of Service: May the State Plan reimburse FQHCs and Tribal FQHCs for different provider services?
  2. Pharmacy: May the State Plan reimburse Tribal FQHCs for pharmacy dispensing at the encounter rate if FQHCs are not eligible for reimbursement of pharmacy dispensing at the encounter rate?

Medicaid State Plan Amendments

SPA 17-0028: Tribal FQHC

- Seeking guidance from CMS on various technical questions
  3. Different Facilities: May a tribal health program have both an tribal clinic and an FQHC at the same address?
  4. HRSA-Funded Tribal FQHCs: May a HRSA-funded FQHC operated by a tribe choose to be designated and reimbursed at the Tribal FQHC encounter rate?

Medicaid State Plan Amendments

SPA 17-0028: Tribal FQHC

- Seeking guidance from CMS on various technical questions

5. Encounter Rate for Any Health Care Professional: May the State Plan authorize the encounter rate for any health care professional (see SPA 17-0042)?
6. Encounter Rate for Services Under Supervision: If the answer to Question 5 is "No", may the State Plan authorize the encounter rate for services "under the supervision".

Medicaid State Plan Amendments

SPA: Pharmacy Reimbursement at Encounter Rate

- HCA conducting analysis

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For January's HCA MTM, what would you like a Social Security presentation on:

- **General Overview?**
- **Retirement?**
- **Survivors?**
- **Disability?**
- **Medicare Enrollment?**
- **Representative Payee Program?**

Quick Planning Query

Washington State Health Care Authority

Office of Tribal Affairs & Analysis

Web: http://www.hca.wa.gov/tribal/Pages/index.aspx

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Thank you!